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BULLETIN of the MENNINGER CLINIC

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SEVENTH ANNUAL MEETING
THE MENNINGER FOUNDATION

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Topeka
Kansas

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BULLETIN of the
MENNINGER CLINIC

VOLUME 13 MARCH, 1949 NUMBER 2

EDITORS' NOTE

Our Children in the Atomic Age

The seventh annual meeting of the Menninger Foundation was held in Topeka, Kansas, October 18–20, 1948. In addition to the meeting of the Trustees, one day—October 20th—was set aside for a series of meetings open to the public and held in the Municipal Auditorium. The program, presented under the auspices of the Children's Division of the Foundation was as follows:

Morning

Emotional Health in Home and School

Presiding—Dr. Edward D. Greenwood, Director of the Children's Division, The Menninger Foundation

Welcome—Dr. William C. Menninger, General Secretary, The Menninger Foundation

The Role of the School in Mental Hygiene—Dr. Alan Challman, Minneapolis, Minnesota

The Child and his Mental Health in the Educational System—Col. H. Edmund Bullis, Wilmington, Delaware

Afternoon

Effective Methods of Helping Children

Presiding—Dr. Sibylle Escalona, Director of the Research Department, The Menninger Foundation

New Ways of Ego Support in Residential Treatment of Disturbed Children—Dr. Fritz Redl, Detroit Michigan

The International Mental Health Congress: A Report—Miss Mary Switzer, Washington, D. C.

Summary—Dr. Karl Menninger, General Director of Department of Education, The Menninger Foundation

Dinner Meeting

Presiding—David Neiswanger, President of the Menninger Foundation

Address: "Can We Save Our Children?"—Marshall Field, Chicago, Illinois

The papers presented have been assembled for publication in this number of the Bulletin for those persons who were unable to come to Topeka, for the many who were unable to get into the meetings because of lack of space, and for those present who requested copies of the speeches. We regret that it has been necessary to condense them rather radically to fit our limited space.

CAN WE SAVE OUR CHILDREN?

By MARSHALL FIELD*

It is a privilege to be here tonight to pay tribute to the outstanding work being accomplished at the Menninger Foundation. The problems being tackled here are crucial to the well being of men and women and children everywhere. And nowhere, to my knowledge, are these problems being approached with a greater background of experience, greater understanding or greater insight.

Your program of the past three days has been so comprehensive that many of my own comments may merely paraphrase your own conclusions without the compensating authority that an expert can bring to the subject.

I assure you that I do not pose as an expert. I would be far more at home discussing some of the problems involved in publishing a metropolitan newspaper. There are many problems these days, particularly in Chicago.

If I cannot qualify as an expert, I would like to mention that my interest in child welfare problems pre-dates the creation of that terrifying new weapon whose existence gives such meaning to this meeting. Child welfare programs in New York, the work of the Ryther Clinic for emotionally disturbed children in Seattle and the program of the Illinois Children's Home and Aid Society have been primary interests for several years.

And two of the most satisfying projects I have ever undertaken relate to President Roosevelt's White House Conference on Children and work with the Committee for the Care of European Children.

So I join you tonight as a sympathetic layman. I know some of the problems you are up against. I know how much *can* be done with proper guidance and adequate assistance. I can appreciate how much remains to be done before any of us can become smug or complacent.

It seems to me that many of the basic problems suggested by the title of your symposium are not new problems. Their roots had gone down many years before Hiroshima. Tonight, as we consider "Our Children in the Atomic Age," we must reckon not only with future *possibilities* but with old *responsibilities*. Even if atomic energy had not been brought under control, we would have to live with those responsibilities.

For example, we would still have to face up to the responsibility of providing adequate housing, adequate medical care, adequate educational opportunity and adequate vocational guidance. These are very real responsibilities but up to now a great many people have taken some very unrealistic attitudes toward them.

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They have argued, in effect, for the right to live in slums, for the right to be sick, for the right to be poorly informed or totally misinformed and for the right to invite personal failure through lack of preparation for the business of earning a living.

And then, having done all these things, many of our national leaders—and would-be leaders—have expressed grave concern for the future of the American family, the nation itself and the role that it must play in international affairs.

In many other countries this conflict between reality and reaction would naturally have personal significance for the children involved. It would mean one more setback to the dignity of the individual child and his unconscious hopes for a whole personality. It would add the tragedy of personal rejection to the tragedy of inadequate food, clothing and shelter.

If we cannot save the children of this country from the fears that breed hatred and aggression and instability, the scope of the tragedy will be far greater. A large part of the world looks to us not alone for leadership or financial assistance but as a last hope for the survival of Western Civilization itself. It is no longer a question of "peace in our time." The issue is "survival in our time." There is as yet no guarantee that this survival can be negotiated. If it can be pulled off, by our generation, it will be a delicate operation, whether it occurs around a conference table or in the ebb and flow of warfare more terrifying than we dare to imagine.

If our way of life does survive this generation, the burden of tension that is passed along to our children may well be the heaviest in the history of mankind. It will certainly be too heavy for those who are emotionally unstable or insecure. It will be too heavy for those who destroy their constructive abilities through fear of the destructive potential of atomic energy or even more sinister weapons yet to come.

The mental health of our children and of all the children of the world is by far the most serious long-term problem we face today. It is linked to most of our other great challenges and upon our ability to solve it may depend all the hopes that give continuity to our lives today.

The problem of mental health is so vast and so complex that many people may doubt that it can be solved. I think these people are unduly pessimistic. I think they minimize the great gains that have been made since the first world war in defining the problem itself and in working out techniques for approaching it. The three-day symposium which you are concluding here tonight is a constructive example of the advances that are being made. A generation ago such a meeting would have seemed as unrealistic as a proposal to begin passenger service to Mars. Today it is accepted as an essential step toward a specific goal. Psychiatry is emerging

from its laboratories and, in spite of many popular distortions of its functions and objectives, it is being recognized for the contributions it can make to better living for everyone.

We are inclined to forget that there was a time when many physical diseases were accepted as either inevitable or the manifestation of some supernatural displeasure with the way mankind was handling its affairs. The medical scientists who attacked these diseases did not have an easy path and many obstacles were placed in their way. They had to triumph over superstition before they could earn the respect of the superstitious.

There is a parallel in the attack on mental health problems. Rarely has such worthwhile activity been subjected to comparable scorn and ridicule. In spite of this we are beginning to reach the point where those who came to scoff will remain to pray for the success of psychiatry in a troubled world. It is now possible to hope that war, for example, is no more "inevitable" than typhoid fever and that the combination of sound minds in sound bodies may make it possible to immunize civilized society against its own compulsion to self-destruction.

Our own folklore provides a significant clue to our hopes. "No one in his right mind wants war," we say. And the key phrase, "in his right mind," betrays our common concern for the sickness of mind that leads powerful men to decide on war as the solution to real or imaginary crises. In the long history of wars, we have had many explanations of their causes. Some have been based on economics, some on political or sociological factors. Rarely do historians agree which factors were primarily responsible for a particular conflict. If we do not destroy ourselves before it is too late, our hopes for the future may lie in understanding that there is just *one* cause of war—the mental sickness of nations infected with the madness of their leaders.

It will be a mistake to imagine that progress can be achieved solely through the careful labor of professional scientists. Progress in the field of mental health can be made, it seems to me, only in an atmosphere of freedom and with the active cooperation of many allies—parents, educators, health leaders and practical political statesmen.

Progress will require the support of all the people and the way to express that support is through a national mental health policy affirmed by the people's representatives in local, state and national governments. And if we are realistic, we will want to see that policy extended internationally with the least possible delay.

All our experience of the past in fighting physical hazards to our well being suggests this need for more than isolated skirmishes in this campaign. The fight for purity in food and drugs was not won until its philosophy became a part of our national policy. The fight for increasingly higher

standards of sanitation has been successful only because it, too, was carried through to affirmation through common sense social planning.

We are a long way from our goal of a world at peace, a world of men and women who can cope with personal and national crises without resorting to destructive and self-destroying aggression.

If we are to reach that goal, there must be action on many fronts. Some steps have already been taken and they are encouraging in many ways. We cannot become discouraged by the length of the journey, or the roughness of the road.

Certainly one of the areas in which important steps must be taken is that of the American family. The American family has been charged with a great many faults during our recent awakening to the importance of mental health in society.

Like a great many institutions from the legitimate theater to the British Empire, it has many times been "written off" as an unnecessary anachronism. Yet the American family continues to survive. It continues to be a force to reckon with.

It is true that there have been many modifications in family patterns. Perhaps it is also true that our discussions, our viewing with alarm, have magnified the real meaning of these changes out of all proportion to the realities involved.

Perhaps many of us who have been concerned with social problems in this country have been guilty of excessive concern with what's wrong with the American family and not enough concern with what is right with it. And in our appraisals of the mental health of our children we may have forgot to seek insight into the nature of the families which produce them.

One of the most constructive results of our explorations in the field of mental health can be the stripping away of the mysticism and overcharged emotional thinking which is commonly associated with the concept of family. The family does not need these trappings. In fact, they encumber all of us, scientists and laymen alike, in our search for more productive living for ourselves and our children. The family is a social organism for getting certain things done. It can be a useful social unit or a destructive one, depending on the capabilities of the individual members and their understanding of what the family can and cannot do. If the family as a social group did not exist, it would certainly have to be invented.

One perceptive observer of our social institutions has classified the functions of the family into categories labelled "essential" and "accidental."

The *rearing of children*, the provision of *companionship*, the development of *emotional security* and the *housekeeping duties* associated with the home are listed as "essential" functions.

There are four "essential" functions listed but it is interesting to note that this same observer lists *six* functions which were once important in the development of family life but which now can be considered merely "accidental."

Creation of economic goods used to be a primary function of the family, for example. So did the *collection and preservation of property*, a function now more closely associated with the modern corporation and other forms of business enterprise. *Government* was once a distinct family function as were *worship and education*. Acceptance of responsibility for all these functions has shifted away from the family. Even *health care*, except in its simplest form, is a function for which the modern family no longer accepts blind responsibility.

Some people see in this trend away from the old "trustee" type of family symptoms of disintegration of the family as a sound institution. They may argue that when so many functions which used to be important to the family are taken away from it, the family will collapse. They may argue that the tensions which characterize so many of our mental health problems will be increased.

This is a pessimistic viewpoint and one which, I am confident, most laymen would join me in disputing. The reason for many of the changes which have taken place is that new units in society have shown their ability to handle many of the old family functions more constructively. As long as these new units prove more efficient, they will continue to provide the basic education, health care and other functions which were associated with the family in a less complex society.

If we are realistic, we will concede that many of these mechanistic functions of family life are not those that will be most important to our children in the atomic age.

The mental health of our children will depend to a far greater degree on the manner in which families discharge three of the four so-called "essential" functions. The way in which we rear our children, the companionship we provide and the emotional security we are able to build in them will determine their chances for survival in the atomic age.

If we can emphasize these constructive qualities in family life, rather than the negative aspects, I believe many parents will work with increasing effectiveness in the development of mentally wholesome children. Today many parents are bewildered by the attacks on the American family. They feel somehow, that because they delegate so many responsibilities to agencies outside the home, they are not being good parents. As a consequence, they fail in the larger responsibilities of providing companionship and emotional security.

To win parents as allies in the campaign for higher standards of mental

health, psychiatric workers face a number of specific professional problems. They must stress the constructive, preventive functions of psychiatry. They must establish what might be called the common sense qualities of psychiatry.

They must make it clear that emotional disturbances in children are not confined to proven delinquents. And they must demonstrate the high degree or correlation between emotional disturbances in the adult and in his child.

When all of us who are interested in child welfare stop talking *at* the American family and begin working more effectively *with* it, we shall have taken one of the first big steps in the job that lies ahead.

If we need allies in the family, the need for them in our *schools* is equally imperative. Our schools have acquired many of the functions which once belonged to the family without the tools with which to handle them. In this new role, many educators are beginning to appreciate the paramount importance of mental health in students. They are the educators who appreciate that the so-called crisis in education does not refer exclusively to matters of curriculum, salaries or new structures. They know that other factors can be more important. They know that failure to reach emotional maturity is handicapping thirteen out of every 100 American school children. They are familiar with the reports that show that eight of those thirteen will have emotional breakdowns, that four will wind up in mental hospitals and that one will turn to crime.

To put it bluntly, they know that the greatest crisis in education is the threat that American schools will continue to handle increasing numbers of emotionally disturbed children without being able to do anything about the problem.

The prospect for the future is not pleasant. Our abnormally high national birthrate during the war means that our school population will climb to fantastic totals. The prediction for 1955 is that 24 million children, aged six to thirteen, will seek admission to our public schools.

That is nearly five million more children than are already taxing our facilities. By 1960 the total will be 34 million children in both elementary and high schools—approximately 25 per cent higher than our total enrollment today.

If our educational system is under pressure now, the tensions that will develop within the next ten or twelve years may prove unbearable. New buildings and more and better teachers promise only a part of the answer—and even that fragment is not forthcoming in many parts of the nation. We are heading straight for conditions in which antagonisms of all types—racial, social, economic—will be almost unavoidable. It is one of the most conspicuous threats to the mental health of our children

and there are few signs of mobilization to stave off disaster. As Dr. Menninger has said: "This is the colossal responsibility that faces teachers—a far, far greater one than merely conveying information."

Encouraging experiments, as we know, are under way. Last month in New York City, for example, the Board of Education opened its fourteenth school in the special organization for the education and rehabilitation of emotionally disturbed children. Every teacher in these schools must have a special certificate of competency awarded for additional training, for evidence of skill in handling maladjusted students and for personality, sympathy and interest. Helping emotionally disturbed children is not the sole aim of the fourteen schools. Some of the special methods used, according to the program supervisors, may well prove to be of value in regular classes.

Encouraging as such isolated cases may be, we cannot afford to wait for a kind of spontaneous ignition to set off the chain reaction that is needed to get a sound mental health program under way. We need a well-organized, concerted attack on all phases of the program. That means a national policy for mental health. It implies national and state legislation and adequate public financing all down the line.

It means a national survey that will give us more facts upon which to base future standards. And I think it should also mean a promotional campaign that will "sell" the concept of mental health to the American people with the same intensity and clarity that is used to sell soap, automobiles or War Bonds. The stakes are so high that we cannot afford to do less than bring to bear upon this problem the best experience and the best talent that can be found to do the job.

The job will not be completely successful unless and until we look beyond our own borders. Mental health for our children will have little meaning if the children of other nations produce another generation of Hitlers, Mussolinis, and Tojos. The irresponsible leadership which such men represent can flourish only where people are sick, without hope, without stability to face the stubborn realities of the world today.

Incomparable difficulties will face us but we have no right to say that the task should not be attempted. Three years ago the concept of the International Children's Emergency Fund of the United Nations seemed fantastic in scope and aspirations. Yet today we know that four million children throughout the world are receiving daily supplementary feedings. We know that *fifty* million children in Europe alone are being examined for tuberculosis and that *fifteen* million will probably be inoculated as a protective measure. We know that the World Health Organization of the U. N. was able to snuff out a malaria epidemic in Egypt in the incredibly brief period of less than two months.

If we can tackle jobs like those in the field of physical welfare, we should not be too timid to approach jobs of comparable magnitude in the field of international mental health. Sound bodies are no guarantee of world peace. We need sound minds as well.

As a newspaper publisher who is also interested in other media for the communication of ideas, I am convinced that no discussion of the mental health of children in the atomic age can be complete without reference to some of the specific responsibilities faced by our press and radio, our magazines and our movies.

A tremendous job remains to be undertaken in this area alone. And the job, I believe, is primarily one of creating a basic understanding of the awe-inspiring power these media can exert for good or for evil. It will benefit us little to repeat the old accusations of responsibility for creating the tensions which we seek to avoid in the future. The literal fact is that many publishers, many broadcasters, many producers do not know their own strength. And there is no reason to suspect that we do not even understand the precise mechanisms through which this strength operates. Before we can say how this strength should be applied, we should have more effective methods for measuring the impact of an editorial . . . or a comic strip . . . or a Western movie . . . or a radio soap opera. Until these yardsticks can be worked out, our value judgments represent little more than the unsupported opinions of unreliable witnesses.

To any layman, the kind of hospitality you have extended to me here tonight is an invitation to the broadest of generalizations. After all, the easiest thing in the world is to tell a professional psychiatrist or a truck driver or brick layer how he should go about his job.

I hope that my intrusion here will not be regarded as yielding to that kind of temptation. What I share with many other laymen is a profound interest in the work you are doing and its potential for making this a better world.

The work being done here at the Menninger Foundation should encourage us all. For it demonstrates that we already have preventive and corrective techniques for helping emotionally disturbed children and that we are acquiring increased skill in using them.

The cost of putting these techniques to work is still high. Ways must be found to reach more children who need help and cost is no excuse for delay in going ahead. The cost of *not* doing the job is far greater. It is a cost that can be measured in terms of personal frustration and constructive work that never gets done, in terms of crowded jails and mental institutions, in terms of the bitter futility of war.

There is an immense task of public education to make people realize that it probably costs at least $3,000 to do an adequate job on a really

disturbed child. Many entire families are supported on this amount—and it is difficult for political office holders in public programs and for those who have to obtain private funds to convince people of the necessity for that kind of expenditure. Even laymen appreciate that no quick panaceas can be found now or are likely to be found in the future. But the job must be done, no matter how many technical problems have to be overcome.

This is the story that we must get across. When the importance of the job is understood by the general public, we will have accomplished one of our first important objectives, but it is not easy.

A New York Times editorial recently re-emphasized the need for more adequate support of the International Children's Emergency Fund. A portion of that editorial might well be required reading for all of us who are concerned for the future of children throughout the world.

"Beyond this emergency help . . ." The Times points out, "is a far graver, long-term problem—the need for child care in the broadest sense, which means emotional and psychological adjustment.

"For millions of these children have known only change, cruelty, war and emotional upheaval. To them begging, lying, thieving have been a means of survival. To them—little old people who have missed living like children—cynism and distrust are their basic philosophy. To them—their world gone up in smoke—it is a worthless world anyhow, where children go hungry and there is no room for love and help.

"This is the challenging problem to nations that tend to overemphasize industrial and economic recovery and forget that human recovery—rather human rebirth—is at least as important."

And to this excellent statement I would add only that the challenge is to all of us, personally and individually, and that if we continue to make the kind of progress that is being made here, I am confident *it can be met*!

THE ROLE OF THE SCHOOL IN MENTAL HYGIENE

By ALAN CHALLMAN, M.D.*

The mental health of our nation is in a deplorable condition. There are 600,000 patients in our mental hospitals today and many of them so hopelessly ill that they must remain there for the remainder of their lives. The exact extent of mental illness and emotional maladjustment in the population outside the hospital has never been determined, but such figures as we have, indicate that perhaps 10 per cent are affected to a materially handicapping degree. This would mean that about 14,000,000 persons in our country are showing obvious signs of mental and emotional illness. Approximately 1,500,000 of these were identified and screened out by the necessarily superficial draft examinations during the last war, among the small proportion of our population called up for induction, and an additional 500,000 who were accepted for military service had to be discharged medically by reason of neuropsychiatric illness. Those rejected and those discharged located 2,000,000 neuropsychiatric handicaps in the slightly more than 10 per cent of our population examined by selective service. In addition to this alarming evidence, all of us so-called normals recognize in ourselves and in our "normal" friends and neighbors the less obvious signs of neurotic traits and character defects which interfere with efficiency and enjoyment of life without constituting a clinical psychiatric problem.

Anyone willing to look at the available evidence and to compare it with the data on the extent of disability produced by other diseases cannot avoid recognizing mental illness as public health problem No. 1. This is also the rating given it by former Surgeon General Parran of the United States Public Health Service.

In spite of the tremendous importance of this health problem it has not received the top priority among public health activities because there are said to be no established methods of cure and/or prevention of most mental illnesses which are sufficiently efficient to be applied in a broad way at the present time. While there may be considerable logic behind this adverse judgment of public health officials, it should not deter those of us who have a special knowledge, interest, or opportunity in mental hygiene from advancing in a broader attack upon this problem to apply what is already known by way of prevention and to discover and prove better methods.

Ways must be found to *prevent* mental illness if any real improvement is to be made in the mental health of the nation. While enough is known

* Minneapolis, Minnesota.

about psychiatric treatment at present to restore many individual psychiatric patients to mental health, the professional effort required is so time-consuming that it is utterly fantastic to think of dealing with the problem of mental illness in our whole population at the clinical level.

On the average, a psychiatrist can adequately keep under treatment or supervise the treatment of about 50 patients at any given time. This is an average which takes into account the great variety of patients who make up the case load, ranging from senile psychotics and deteriorated schizophrenics where the proportion would be about 150 patients to 1 psychiatrist, to severe neurotics or acute psychotics where the proportion would be 10 or 15 patients to 1 psychiatrist. If one then considers the 14,000,000 potential patients and the 4,000 psychiatrists, there would be 3,500 to 1. If only 1 in 4 of these potential patients was found to be treatable and to desire treatment we would still have a ratio of around 600 patients to 1 psychiatrist.

This is still fantastic. It would take 48,000 psychiatrists to treat those 3,500,000 selected patients; and 48,000 psychiatrists represents one-quarter of the entire medical profession. Even if 48,000 psychiatrists could be created overnight by some stroke of magic it would require an annual crop of 1,600 replacements to care for normal attrition due to death and retirement. Our medical schools are not capable of supplying this large number of psychiatric residents in addition to other graduates.

In illustrating the impossibility of solving our mental health problem at the clinical level, I have spoken only of the man-power problem in psychiatrists. I am well aware that clinical psychologists, psychiatric social workers, and psychiatric nurses, when they have been trained in therapy, can supplement and extend the psychiatrist's therapeutic effectiveness quite considerably. But experience has shown that psychiatric team-work as practiced in clinics does more to improve the effectiveness of the therapy and to provide professional training than it does to increase the case load much beyond the range of fifty active cases per psychiatrist. Furthermore, the same manpower shortage exists in the fields of clinical psychology, psychiatric social work, and psychiatric nursing as in the field of psychiatry, and there is a similar dearth of training schools for these disciplines.

It should be crystal clear that a clinical approach to the widespread mental illness in our population can only touch those patients who are grievously ill from psychosis, and a portion of those who are completely incapacitated by neurosis, plus a few relatively wealthy individuals who can afford private psychiatric treatment. It is not merely inefficient but actually impossible under present conditions, or any conceivable expansion of present treatment facilities, to allow mental illness to develop through

willy-nilly methods of education and then to attempt to cure it through clinical effort.

This is not to say that there is no place for clinical psychiatry and its allied disciplines, for there is and always will be the need to care for those who become mentally ill in spite of preventive efforts. It cannot be hoped that prevention will ever be 100 per cent effective in a field as complex as this, since we cannot even attain that degree of perfection in such a disease as small-pox where preventive measures are simple and admirably effective. Preventive measures can be expected to reduce mental illness and emotional maladjustment but never to eliminate it. Furthermore, a population whose mental health is adequate for ordinary conditions can still develop a high rate of mental illness under abnormal conditions of stress and strain. During the late War, I was assigned to the Chief Surgeon's Office in the Western Pacific Theater and kept closely in touch with psychiatric rates of incidence. Over in those islands conditions of life were such that our soldiers, who had been psychiatrically screened at induction stations and screened again as they went through their training and preparedness for departure overseas, showed an incidence of psychosis of ten per thousand per year, which is *twenty times* the incidence of psychosis in wholly unscreened young men of the same age living at peace in this country. In addition to the high rate of psychosis there were nearly four times as many who became incapacitated by neurosis and other minor psychiatric reactions. I think it significant for our future planning to realize that it is not only the mental and emotional stamina of the individual which is important in a preventive program, but also the quantity and the quality of environmental stress that must be met by the individual. Therefore, any thorough preventive program must have an effect upon political, social, industrial and religious institutions as well as upon the individual.

There are a vast number of ways in which a society's mental health may be improved, but I believe that in a democracy the most basic of these and the one which must carry the leading role is found in our school systems. This is so not only because the school is the social agency having most to do with the shaping of children's personalities, instilling personal standards, and providing techniques for dealing with reality, but also because educators are on the whole far advanced beyond the rest of our population in recognizing the importance of childhood experience in promoting or hindering life adjustment patterns. I think educators are pretty well "sold" on mental hygiene in the classroom and school, although many of them are at a loss to know how to progress further toward the goal they have already accepted. I wish I were in a position to answer all the practical questions that immediately arise when one wishes to

make advances in a school mental health program. I have spent eight years of my professional life as a shool psychiatrist and clinic director in Minneapolis and New York City, so I know most of the problems, but unfortunately, only a few of the answers. I, therefore, offer the following observations and recommendations in all humility as the effort of a psychiatrist who has worked in two school systems with problem children, problem teachers, problem supervisors, administrators, and board members, and last but not least, problem parents, community leaders, and voters. These elements all form an intricate tangle which would make the Gordian knot seem like a simple bow.

A school program for the improvement of mental health should have two principal targets in mind: i.e. the teacher and the pupil. The teacher should be viewed as a person as well as an instructor, and the pupil should be thought of as a future parent as well as a child. In taking these two groups up separately, I would like to consider initially what can be done to help the teacher.

The first thing, it seems to me, is to *begin improving conditions of work and community living for teachers.* At present teachers are generally expected to be living examples of the community conscience. They must represent all that is good and holy, and do it cheerfully on a salary which is designed to cause a single person with no dependents to scrimp a little, since it is widely felt that poverty becomes a teacher—for after all, she is almost like those in the orders of the church. This austere, bloodless sort of life, which the community attempts to force upon teachers so generally, provides, in conjunction with the experience of living with immature minds for five hours a day, the basis for an occupational hazard which *should* interest the State Industrial Commission—and *would* if it were not so subtle.

Hard rock miners get silicosis from too much dust in their lungs and are retired on compensation, but teachers get pedantic, coarctated, frustrated, anemic, or embittered personalities from the rarefied, sterilized air they breathe, and must work until they are ready for a wheel chair because the pension is so small. It isn't so much that peculiar people go into teaching, as you can see if you stroll across the campus of any teacher's training school or college of education; it is rather that the life forced upon teachers by the community tends to make them peculiar. Of course, in time, teachers become embittered by it all and act as their own police force to require compliance with the high code from youngsters in the profession.

To avoid these occupational hazards teachers (a) should be paid salaries befitting their education and station in life; (b) should be free to indulge in any of the petty vices which are ordinarily accepted without comment in

the average respectable citizen of the community; (c) should have a powder room in the school building where they can smoke during free periods if they wish; (d) should be free to go to public dancing places and night spots when they choose; (e) should be allowed to marry without losing their position; (f) and should be relieved of carping, hypercritical, supervisory visits from specialists who surrendered their humanity a generation or so ago to get out of the grueling classroom. Unless changes such as these are made, we can expect not only a continuation of the unhealthy warping that is going on in teachers' personalities as a result of the occupational hazards, but also a continuing dearth of young people entering teacher training institutions with the consequent necessity for school systems to employ almost anyone who is technically qualified to teach without regard for the influence of her personality upon children. It is impossible to take the next essential step in improving classroom mental health unless there is surplus of potential candidates for teacher training.

The second proposal I would make with regard to teacher mental health is that *a system be set up to determine, before matriculation in a professional training school for teaching and before employment in a school system, which are the healthiest and most constructive personalities among the applicants.*

Most of the large school systems, at least, already have required physical examinations and physical standards before employment. It is unthinkable that a teacher with active and communicable tuberculosis would be employed or retained in a teaching position. Yet the seeds of mental illness are just as readily passed from adult to child as the germs of tuberculosis. We must appraise the teacher's personality from the standpoint of its effect upon children's mental health just as seriously as we judge her physical fitness to be in daily contact with children.

The need for this step in advance is clear, and still it can be argued that we do not yet have sufficiently reliable tests, measurements, and interviewing techniques to set up personality standards for teachers or training school candidates. While this is true to a certain extent, we do have personality examination techniques which are adequate to pick up the grosser deviations from normality with a high degree of certainty, and in my opinion we should make a beginning with the best we have at present and refine our methods as we gain experience. A parallel to this situation can be found in the medical profession where diagnoses of consumption were made long before we had the microscopic methods of identifying bacillus tuberculosis; and diagnoses of syphilis were made before we had developed blood tests. It is true that errors in diagnosis occurred before diagnostic techniques were refined and even now errors are still being made in the diagnosis of those diseases, but if society is to delay its effort to evaluate a teacher's mental health until a perfect examination technique

is discovered it will have sacrificed the mental health of thousands of children who could be saved from personality distortion even with our present unrefined methods. Even many industrial establishments who have nothing more than a dollar profit at stake have begun evaluating the personalities of their applicants for employment.

My third proposal regarding teachers is that *they should be instructed in the teaching of principles of mental health.*

Academic education is supposed to be a preparation for life and yet we are allowing children to grow up haphazardly with respect to the laws of mental health. Time is being spent teaching children multiplication and division of fractions, rules of grammar, how the Indians build their tepees, etc., but practically nothing is being done to teach children what happens when personal ambitions run too far ahead of the individual's capacity for performance, or how better to understand and deal with the people they must get along with in the world. Adolescents are being instructed in foreign languages, algebra, and geometry, the country over, but practically nothing is being taught about marital relations in the broader sense. Girls and boys are receiving vocational training in fields they will have very little use for in later life, and yet are given no instruction in how to be a good parent, which most of them will stand in need of almost every day of their adult lives.

There should be instruction in the principles of mental health as they are applied to oneself, and to one's children, but at present teachers are not prepared to give this instruction. One of the most serious obstacles to this advance is that textbook material has not been sufficiently developed for the introduction of such instruction into the curriculum of most schools and teacher training institutions. I believe this is an area that needs diligent cultivation and the cooperation of a variety of experts in the fields of education, sociology, psychiatry, psychology, and religion. Each of these fields has a unique contribution to make to such teaching material and finally the end product must be acceptable to the majority of parents. It would seem to me that the Federal Office of Education is in an excellent position to organize the various elements needed for an attack upon this problem. We need a substantial agreement upon the principles that are to be taught, before the techniques of training teachers in such subjects and incorporating such instruction into the curriculum of the average American school can be worked out satisfactorily. It seems to me, however, that this is an essential step which must be made if an effective program of prevention of mental illness is to be carried on.

I would like to turn now to what can be done to help the pupil directly. Of course, all that I have said under the heading of what needs to be done for the teacher has at least an indirect bearing on the mental health of the

pupil; furthermore, if teachers are prepared for and given materials and curricula for instruction in mental health principles and parental functioning, the pupil is thereby affected directly. In addition to these recommendations, which are for the purpose of placing the pupil under the tutelage of a mature and well adjusted person who will help him learn how to manage his own life and exert a constructive influence on his children when he has them, there are other things which should be done for the sake of the child's own mental health. These can all be grouped under the heading of making known the ways in which this child differs from others, or the average, so that he may be understood, guided, praised, and blamed in consideration of what he *is* rather than what he *is not.*

Every school should have a workable system of accumulating pertinent information about each individual child so that his needs may be quickly sensed and provided for as he passes from one teacher and one school to another. The form or folder which contains such information is often referred to as a Cumulative Record. Such a record can and should be readily available to every teacher under whom the child works. Teachers are often harangued and importuned at meetings and conventions to treat each child as an individual and to suit his instruction to his current needs. The teacher, however, while recognizing the desirability of this, is generally unable to lay her hands on information about the child's capacities, needs, and differences which will allow her to approach the goal of individualized standards and instruction. It used to strike me when I was a school psychiatrist, as unfair to the teacher to expect her to appraise the needs of her individual pupils with so little information at her disposal, whereas I, who had the advantage of many years of special training and experience in appraising personalities, wouldn't venture an appraisal of a problem child until I had obtained a social history, a physical examination, and a battery of psychological measurements. The teacher needs the same variety of data that a psychiatrist needs if she is to be expected to individualize the management of her pupils. Her cumulative record should contain:

1. Personal identifying and family data, such as name, address, date of birth, siblings names and birth dates, parents employment, etc.

2. Physical health data such as visual and auditory acuity, handicapping chronic diseases or defects, nutritional status, etc.

3. Intelligence test results based on an individual intelligence test given to each pupil at the kindergarten or first grade level with periodic checks on group intelligence tests every few years. In 1935 while I was in the Minneapolis school system my department had the responsibility of training kindergarten teachers in the administration of individual intelligence tests to their own pupils. Such testing has been done there routinely ever since and under the name of "school ability test" has

occasioned no undue curiosity or resistance among parents, and yet has supplied valuable information to teachers throughout the system. Statistically adequate tests of reliability have shown the kindergarten teacher's test results to be accurate.

4. Objective achievement test scores in tool subjects such as reading, spelling, and arithmetic. These should be given at the end of each school year until a competency in the tool subject has been attained.

5. Record of subjects previously studied and grade obtained on each.

6. Personality data, giving information gathered by each teacher as she comes to know the child, relative to his interests, special abilities and disabilities, personal peculiarities, and ways in which his cooperation and best effort is obtained.

Such a system of gathering and recording pertinent information of each pupil is an essential to mental hygiene in the classroom.

In closing my remarks I wish to make it clear that what I have herein proposed is not by any means a comprehensive program for improving the deplorable mental health of our nation. I have spoken only about desirable changes within the school, and the school is only one of the many areas of activity for mental health work, although perhaps the most important of them. Furthermore, I have felt it unnecessary to mention the many excellent principles and practices which are already widely established in educational work and are doing their share to build healthier personalities in our children—such things as improved curricula; groups of slow, medium, and fast learners; remedial reading work; more constructive reporting systems to parents, and personal relations instruction. The points I have made were selected largely on the basis that they are not extensively practiced, although certainly none of them are untried or completely untested, and yet sufficient groundwork has been laid for each of them so that they represent appropriate current salients for a mental hygiene campaign. May I close with a prayer that it will not be too long or too late before we see them in general practice.

THE CHILD AND HIS MENTAL HEALTH IN THE EDUCATIONAL SYSTEM

By COL. H. EDMUND BULLIS*

Leaders in the field of psychiatry have always been interested in education. Generally speaking, however, this interest has been directed toward medical and psychiatric education. It is the exceptional psychiatrist who has been closely identified with elementary schools. Of course, many in child guidance clinics or in private practice are quite familiar with seriously emotionally disturbed children of elementary school age.

Shortly after the mental hygiene movement was started over forty years ago, the problem of the mentally deficient child in school was given constructive attention. Out of this interest of a comparatively few psychiatrists working with educators, training schools for the mentally deficient were started in practically every state. Laws providing that children of very low I. Q. must be kept out of public school classes were passed. Special or opportunity classes for the 50 to 75 I. Q. group were established in thousands of schools. Also as a result of this interest, many schools started giving special consideration to the dull, normal child; and adopted the homogeneous grouping of children according to their intellectual capacities. Educational arrangements for dull, normal children are still far from satisfactory due to the fact that the great majority of them throughout the United States are going to school in communities where there are no opportunities for either trade school or special class training. Consequently, we find too many of this group in delinquent activities and decidedly maladjusted.

The early 1920's saw the National Committee for Mental Hygiene becoming interested in the establishment of child guidance clinics, and with the generous financial support of the Commonwealth Fund, demonstration clinics were launched in many different parts of the United States. It was in these clinics that the traditional team of psychiatrist, psychologist and psychiatric social worker came into being. However, comparatively few school systems now have child guidance clinic setups.

From time to time great stress has been laid on parent education by mental hygiene leaders. We have never found a practical way of helping train those parents having the most difficult problem children. We have not been able to get many of these parents to attend classes. Most of the parents desiring mental hygiene training were already well adjusted and doing a good job with their children. I have come to the conclusion that

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the only practical way to educate parents in emotional matters is to start training children in the hopes that they may gain proper insights so that each succeeding generation of parents will become more understanding.

At one time a few leading psychiatrists gave decided attention to the visiting teacher movement. This, to my mind, was a most practical step in the right direction. However, as the years went on this interest was largely dissipated. Again, from time to time, certain psychiatrists have been tremendously intrigued with the possibilities of the better utilization of public health nurses in schools—a most practical idea but one which has not been carried through in any systematic way.

Occasionally I find psychiatrists on the annual program of various recreational and youth organizations—another most important field. Generally speaking, however, the emphasis of practically all of these contributions by psychiatrists to the groups working with youth has been entirely focused on those children already exhibiting emotional problems.

I have been connected with many mental hygiene projects in schools. The most unsuccessful one was our attempt to find ways and means to eliminate maladjusted teachers in service. In several large cities we located a number of teachers, generally old in service, who were very definitely maladjusted—in certain instances, almost to the point of being psychotic. Some of these teachers were psychiatrically examined. But when we proceeded to try to get their resignations or to ask for their retirement, we were completely defeated. In practically every instance the sentimental support of old graduates or others was mobilized to help such teachers; and although we definitely knew they were harming the children, we were unable to find ways of getting such teachers out of the school system. The result was that these unfortunate teachers would be transferred from school to school, given difficult and almost impossible assignments with the hope that they would ask for retirement or resign—but to no avail.

During 1932 and 33, at the height of the depression, the National Committee gave a great deal of time to conferring with outstanding educational leaders throughout the country to devise ways and means by which special consideration could be given to personality qualifications in the selection of teachers. For several years at this period when tens of thousands of outsiders were trying to get into the teaching field because of the security it afforded, we were able to make progress in some of the teacher-training colleges and in some of the large city systems. That time is past. Now we are so badly in need of teachers that we will take almost anyone regardless of his or her personality qualifications.

In the early 1930's the National Committee and other interested groups

set up many mental hygiene institutes and training courses in mental hygiene for teachers. These courses have continued to expand so that practically all teacher-training colleges have mental hygiene courses. In my biased opinion, however, too many of these courses are very little more than courses in abnormal psychology. Many, many mental hygiene books, magazine articles, and pamphlets have been written for teachers. I have talked to hundreds and hundreds of teachers who have taken these courses and kept up with the mental hygiene literature. While these teachers have increased their vocabulary of psychological and psychiatric terms and know more as to the mental mechanisms of children, they have not—generally speaking—gained very many practical insights which they can actually use in their classrooms.

In 1932 the President of the Carnegie Foundation for the Advancement of Teaching personally told me, "You who are in the psychiatric and mental hygiene fields are not making much progress with teachers in the elementary schools with your philosophical books, pamphlets, lectures and courses. What the teachers need are practical handbooks and lesson plans that they can use themselves in their classrooms with their own students." This comment from one of the leading educators in the United States, a man who was sincerely interested in our field, was largely responsible for my starting to try to produce practical lesson plans that could be used to teach positive mental hygiene principles to boys and girls in our elementary schools.

I do not have to tell you that the primary cause of the great majority of the problems of family, community, industrial, national and international life facing us today seems to be the inability of individuals and groups to get on with one another—faulty human relations. Every indication seems to point in the direction that we are becoming a more neurotic people.

I feel we must follow the lead of public health workers who have developed successful techniques to build up resistance in individuals against certain physical diseases. Just as we used atabrine in the last war to make our men resistant to malaria, I feel we must find ways and means of building up resistance in our boys and girls so that they may meet emotional crises in later life without breaking mentally.

I do not claim that our Human Relations Class methods, which are now used in classes of more than 200,000 boys and girls located in every state, are a panacea. I am sure that these plans could be greatly improved if the serious attention of educational and psychiatric leaders of the country was directed to the problem of helping normal boys and girls become more emotionally mature. Yet, this is not the way psychiatrists have directed their efforts in the past. Here in this great Menninger training center,

most of the psychiatrists are being trained for clinical work of one type or another or for medical faculties to train other psychiatrists to continue working to help patch up emotionally disturbed individuals of all ages. If we had four times the number of well trained psychiatrists that we now have, we could not keep abreast with this patching up process. We must in some way do one or both of the following in an endeavor to devise practical, preventive planning measures:

1. Train a number of psychiatrists who will devote their entire attention to preventive efforts.

2. Give selected non-psychiatric leaders adequate psychiatric insights to help them take real leadership in preventive activities.

To be effective in preventive procedures, psychiatrists must become experienced in many types of problems ranging from handling of relief to housing; from labor management relations to discussion groups within the community; from the emotional damage resulting from certain movies, radio or television programs to the advertising practice of making millions of people dissatisfied with what they have so that they will buy new products.

If we fail to produce psychiatrists who can be used for top level national policy planning, we must find ways of giving selected leaders in other fields psychiatric insights to help them so that in national policy planning consideration will be given to the emotional stresses which may be imposed on our people by sudden changes in far-reaching policies. Up to the present time, I feel that little progress has been made in this matter of giving psychiatric insights to non-psychiatrists. The average psychiatrist is a perfectionist; he does not like half measures. He shudders to think of untrained people dealing with the emotional problems of normal or abnormal people. Too many psychiatrists feel that there is no short cut to giving others psychiatric insights; they feel that insights come only with very complete training and long experience. Here and there I have known psychiatrists who have been decidedly helpful to groups of personnel managers, clergymen, management executives, educators. These efforts have generally been spasmodic and not related to one another.

On numerous occasions I have invited psychiatrists to meet with important groups of guidance teachers to try to give them better understanding of how to meet certain emotional problems of children in the school. On most occasions I have been bitterly disappointed in the results. Psychiatrists have generally talked over the heads of these teachers and afterward have told me that the guidance teachers did not have enough insight and understanding to be helpful in the delicate art of guiding youngsters. Yet these guidance teachers are handling tens of thousands of maladjusted children daily and will continue to do so for years to come.

We cannot continue to take such an attitude, for it is very doubtful if we will have better qualified teachers ten years from now. There is a decided dearth of young men and women entering the teaching field; and yet ten years hence we must have almost a million additional teachers in our school systems than we have now to take care of the increased load of children who will be in school at that time. The recruitment and training of these teachers is a most serious problem confronting our country which has been given little consideration by psychiatrists. It is no wonder that more people do not go into teaching. In my opinion, it is not merely a matter of compensation; it is quite largely due to the fact that we do not give our teachers sufficient recognition for their work. In many communities teachers are not socially accepted.

We need to divert a portion of the psychiatric service now being given to individuals to the consideration of practical problems such as—how can we help teachers obtain more emotional satisfactions from their work; how can we give them more recognition and allow them to lead more normal lives; how can we give them better understanding of themselves and their pupils? In England and on the Continent, for instance, the profession of teaching is looked up to. We are surprised to find any men teaching in elementary schools in the United States, yet we could use tens of thousands of well adjusted men in this work to advantage.

Public health leaders have dodged responsibility in the field of prevention of nervous and mental disabilities by focusing their attention on the prevention of physical disease; they have "passed the ball" to psychiatrists. The average psychiatrist is highly trained clinically. However, he is not fitted either by training or experience to operate effectively in the epidemiological approach necessary in successful preventive activities. Educators have been reluctant to assume active leadership in this field as they have been informed too frequently by psychiatrists as to their lack of insights and understanding of the emotional problems of children.

We are losing the game. We must have new and enthusiastic leadership, more practical tactical plans, more active and trained players.

Successful preventive work in the field of emotional maladjustment must be carried on by those working closely and daily with children—teachers, school nurses, public health nurses, youth and recreational leaders, church youth leaders, and parents. Psychiatry should provide qualified experts to serve on a top-level policy planning group with public health leaders, educators, and others to outline a national, long-range effort for improved mental health—a truly preventive effort. Educators, because they have more contacts with boys and girls than does any other professional group, must take the responsibility for directing and operating this proposed preventive effort.

NEW WAYS OF EGO SUPPORT IN RESIDENTIAL TREATMENT OF DISTURBED CHILDREN

By FRITZ REDL, Ph.D.*

If you choose, as victims of your therapeutic ambitions, hyperaggressive delinquents from tough slum neighborhoods, you soon find yourself in a situation of most fascinating technical embarrassment. For it is obvious and has long been conceded, that these children cannot be approached by the classical techniques of child psychiatry, so well established in work with neurotics from middle-class neighborhoods. It seems that these children need a strengthening of their control-functions before you can even survive with them, and, while you reel under the first impact of life with them, you are easily convinced that their problems are quite different from those for whom our classical techniques have been designed. You are reluctant to try to undo more repressions—it doesn't seem they need encouragement along that line—and before you would risk further id-analysis, even if you knew how, you would certainly want to have some guarantee of what they would do with newly released id-contents. It seems that the views of previous researchers have been corroborated: these children need synthetic help up to a certain point before you can aim at them the analytic guns of the more traditional approach.

This statement, however, confronts us with a most embarrassing discovery. We seem to know little as yet about the specific functions of the ego; and the techniques of "ego support" about which we talk in our traditional analytic work with middle class neurotics, do not seem to apply here. Whatever mild forms of "ego support" we use in a classical analysis, the techniques all presuppose the very functions which seem to be disturbed in the group I am talking about. We can not "point out reality limitations" to these children. They don't like to talk and they can't listen (certainly not to us, the symbols of a world of hostile adults they have learned to fight with the ruses and devotion of a political underground) and the use of traditional techniques of ego support already presupposes the existence of processes of transference, identification, etc., for the very establishment of which we would have a long way to go. The result of this technical problem is obvious: child analysis does not find many children of this description among its clients. Even treatment institutions in mental hospitals have excluded them from their clientele, sticking rather to the more manageable "delinquent on a neurotic basis." However, evasion, no matter how realistically understandable, has never solved a research

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problem yet. And, frankly, our own deep desire to avoid the unpleasant implications of lack of success with this type of child became the main motivation for concentrating a special experimental study just on this phase of the problem. This is how Pioneer House became a reality in the fall of 1946.

Pioneer House, an Experiment in Residential Group Therapy

The Children: Five toughies between eight and twelve years of age, were picked because their disturbance patterns fitted the above description and combined the usual array of "delinquent" behavior with serious ego disturbances along pre-psychotic lines.

The Staff: Case workers and group workers, a whole flock of them, lived with the children and worked with them under my direction, in a carefully planned design of "total group therapy in a residential home."*

Duration of the Experiment: The experiment lasted about two years. During the summer of 1948, in the most successful phase of its development, professionally, the house had to be closed for the simple lack of finances. However, a follow-up budget was made available for case work, foster home care and a club program for these children for another year. The project was financed entirely by the Junior League of Detroit. While it is impossible to describe more of its design here, or even to hint at the most fruitful observations and results along many lines, I shall make a few remarks on the nature of our work.

Residential Treatment Means Group Therapy

For a long time, residential or institutional treatment has been accepted as a half-hearted use of "environment" and "recreational group life" in a "supportive" way. This is usually done on the assumption that it can be handled by minor and badly paid manipulative apprentices, as long as they abstain from at least the most lurid cruelties to children. It is usually taken for granted, however, that the "real" treatment happens during the few hours the child spends in play or verbal interview with the psychiatrist who does the "therapy," and benignly keeps the neck-washing personnel from making too many mistakes and obstructing his success.

We do not doubt that there is a place for institutions of just this type. Children who need individual therapy as the main vehicle of their recovery will benefit from it greatly. However, this is *not* what we mean by residential treatment. We think we have materials to prove that residential treatment of ego disturbed children has possibilities far beyond this. In our experimentation in the Detroit Group Project and in its Summer

* For further information, see "Pioneer House." Write to School of Public Affairs and Social Work, Wayne University, Detroit.

Camp, we had developed a design of "total group therapy" which seemed to imply that the group situation as such, with its implied dynamics, can be used as a direct therapeutic agent, over and beyond what individual therapy may have to be included in such a framework. Pioneer House was an attempt to apply these findings on the basis of a year-round residential pattern. While not forgetful of the importance of the "marginal use" of individual and group interview situations, ours is basically an attempt to show that:

Action grouplife offers a marvelous chance for therapy in itself.

Group dynamics produce emotional "currents" which can be switched on and off for therapeutic purposes, over and beyond individual relationships between children and their therapists.

The most important persons in the process are the people who live with the child in daily contact.

Most of the therapy takes place in real life situations around eating, getting up, going to bed, playing, working, and every phase of daily life, rather than in selected individual or group interview situations.

The impact of the total residential group atmosphere and organizational structure is as much a part of the actual therapeutic process as what goes on between child and adult in the more classical form of play interviews.

I think we have enough evidence in our extensive recordings over the two years, to demonstrate the possibility and clinical validity of such a design, and to show the difference between a "home for children in which treatment is being done" and a "residential treatment home on a group therapy basis." I also think that we can answer a large number of the obvious technical problems arising out of such a reversal of the usual therapeutic design, and we shall try to do so in our publication on Pioneer House planned for the summer of 1949. For presentation here, however, we shall have to limit ourselves to just *one* aspect of the total job: our experimentation with new techniques of "ego support" which such a concept of residential group therapy seemed to offer us.

[At this point in his address, Dr. Redl went on to present twelve different forms of "ego disturbance" in these children and to indicate an equal number of techniques of ego support which have been developed in his work. In preparing this condensation for the *Bulletin*, he wrote, "Since all this material is very deviant from the traditional design of psychiatric treatment and involves the introduction of new and more differentiated conceptuology around the problems of "ego support," a short summary of the main bulk of my presentation cannot be attempted. Instead, I shall substitute a mere outline of the points raised, hoping that it will stir up curiosity which we may be able to satisfy in future publications."]

"Ego Support" Techniques

1. A "weak ego" often means the existence of more impulse tension than the ego can cope with. Technical conclusion: the total life program of the children has to be designed so that adequate *impulse drainage* avoids overstimulation, pathological impulse pile-up, and so forth.

2. Disturbed egos usually are unable to handle *frustrations* adequately. In order to strengthen ego functions, we have tried to use a variety of techniques which we summarize under headings like: "antiseptic programming," "in-conflict aid," "hypodermic affection-support," etc.

3. Ego weakness and disturbance usually also involve inability to grasp or accept the "reality pattern" in which children live, especially its rules, routines, time and space arrangements. Studying the various disturbances of our children along these lines led us to a variety of procedures in which, we think, every institutional worker will be interested. We talk, in this connection, about concepts like: "avoidance of managerial comfort rules," the use of "protective routine" and "organizational crutch-support" and have found the *manipulation of rules, routine and time arrangements* one of the most crucial factors in our successes as well as in our failures.

4. Disturbed egos seem to have a special problem of meeting the onrush of their own impulsivity: anxiety blocks in moments of impulse danger as well as absolute lack of control in moments of seductive overstimulation, seem to be the major risks. We are used to discuss, under the heading of *protective interference*, techniques designed to help weak egos against the onrush of unmanageable impulse-ego conflicts. We have developed a host of criteria for *protective interference*, and are fascinated by the possibilities of "antiseptic grouping" and of "subgroup insulation" against the danger of "group psychological intoxication." Out of our frantic effort to cope with these factors we have started a special study on "Group Contagion and Shock Effect" under the auspices of the U. S. Health Service, which is now under way in Detroit.*

5. Another handicap of "disturbed egos" seems to be their inability to maintain anticipatory images of previous structured satisfactions, which would help them find acceptable resources in moments of boredom or crises later on. On this basis we have experimented with ways of creating *well structured game situations*, and of special *rub-in techniques* to make their image last, so that children suddenly hit by moments of impulse surplus or ego weakness, or both, can still retain enough imagination to use such structural images as a present guide.

6. The greatest problem of our children seems to be their heavy resistance toward any and all adult interference, which it takes many months to break down. During this time the heavy use of patterns of *depersonalized control* seems to be the only way out. We found that many neighborhood games have such a high level of native group code acceptance, that their structure offers the ego-control patterns which can be accepted without

* See: Fritz Redl, The Phenomenon of Contagion and Shock Effect in Therapy Groups, Chapter in *Searchlights on Delinquency*. New York International Universities Press, 1949.

loss of face or without surrender to adult leadership, at least on a temporary basis.

7. By *interpretive decontamination of experience* we refer to the tremendous importance of using "hot life conflicts" for "reality rub-ins" in life with the children, but we also refer by this term to the host of technical cautions which such a concept implies. We are, however, deeply impressed with the great chance which the closeness to daily life, daily conflict and mistakes offers the clinician, in contrast to the traditional seclusiveness of the action-remote interview technique.

8. By *build-up of realistic role expectations* we hope to counteract the peculiar difficulties of "weak and disturbed egos" in differentiating between real behavior of people they live with and the hangovers from their old case history personnel. This implies great care in *role consistency* of all staff that meets the child, and ways of continuous *role interpretation* whenever role confusions arise. Our attempt to meet the dangers of a multiple treatment personnel with already reality-confused children will fascinate all those who work in treatment homes.

9. By *action interpretation* we mean a process which is meant to make up for the impossibility of using verbal interview work, especially in the initial treatment phase. We have materials to prove that occasionally the mere consistency of handling case history determined tantrums in a clinically strategic way, had the same effect, after several months of reality clarification, as verbal interpretations in the classical interview technique would have, were it usable. The impact of such themes for work with hyperaggressive and nonverbal types like these seems to us rather heavy.

10. By *group psychological impregnation of adult personnel* we refer to the one and so far only way we have found with children, whose defenses against adult interference are supported by identification with a heavily delinquent tough neighborhood group code. Such children may establish "friendly" relationship with isolated therapists, but they do not allow those relationships to enter the stage of real identification. We noticed, however, that the insertion of the therapeutic personnel into the group climate of their daily life, offers possibility for "treatment rapport" undreamed of heretofore. Possibilities and limitations of this sort constitute one of the most fascinating experiences of our work in the group project at camp and at Pioneer House.*

11. By *group code insertion of non-explainable reality factors* we mean something so complex that it defies short-sentence-description. Maybe an illustration can do the trick: At a certain level of development, our Pioneers [children] were ready for much more "outside-the-house programming"

* See also: F. Redl, Gang Formation and The Treatment of Juvenile Delinquents, *The Psychoanalytic Study of the Child*, 1:367-377, 1945.

and were in need of less protective reality contacts. However, they were *not* yet ready to have enough imagination about reality dangers, as for instance, the consequences in heavy traffic of reckless station wagon behavior (jumping out in the middle of traffic, climbing out of windows on roof, wild fighting, etc.). "Reality" interpretation of such behavior was impossible at the time; actual suppressive attitudes on the side of the adults would have defeated the very program opportunities for which we had taken them out. We managed to circumvent this problem by a planned propaganda effort to make misbehavior in the station wagon as group rejected an item as tattling on a pal or "acting like a sissy" in their native group code. With this temporary support we could enable a reality-blind ego to be exposed to the very experiences by which we hoped to strengthen it, without having to wait for full recovery to handle the total job.

12. *Provision of satisfaction guarantees and security symbols* through total residential life exposure is the sentence we use to allude to the many "little ways" through which a confused ego is helped to relax its impulse-fears. Under this item fall concepts like: *group atmospheric support, provision of selected symbols for total life security* ("Our Club," planned propaganda for the concept of "We, the Pioneers"), and a lot of indirectly supportive policies: for instance, *chance for a lot of waste* in arts and crafts so as to convey our real acceptance of imaginative experimentation, and our real wish for them to have fun, which for these children would not be conveyed by words, but by our real reaction to their provocative challenge of wasting materials for a long time.

The discussion of the implication of this item for every phase of residential life, from the cook who *must* cook with libido (besides her other ingredients), to the problem of pocket money, candy, chewing gum, smoking policies, bedtime routine, washroom policies, table serving and so forth, would most interest the institutional practitioners.

Summary

The following statements are meant to safeguard this highly condensed report against misunderstandings:

1. Residential group therapy is *not meant to be a substitute for individual therapy*. It is a substitute only for certain types of ego and character disturbances so far not reachable through classical channels of child therapy. For many other disturbance types the already developed techniques are perfectly sufficient. For cases of mixtures between neurotic disturbances and more serious ego disturbances, the treatment of residential group therapy outlined above is meant as a *preparation* rather than a substitute for individual treatment. After getting the ego of some of our

children to a point at which it can survive with others' egos and with the therapist, remainders of more clearly neurotic phases in their problem development must be picked up in traditional child therapy ways.

2. *Group therapy is neither shorter nor cheaper* than individual therapy. On the contrary, for the children I am talking about, I am convinced that for the next thirty years it will be longer and more expensive. I seriously object to the "quacky" way in which group therapy is currently sold to the public by otherwise most serious and reliable therapists. As far as we in Detroit are concerned, we do not look for ways to make the treatment of what we already know shorter or cheaper. We are trying to develop ways of treatment for *what we do not yet know how to treat.* And, as you can see, we would rather stop what we are doing successfully and hope for future chances, than to surrender to the shortsightedness of the money holding public or of foundations' managers, by compromises on a qualitative level, or by a compromise with the "numerical naiveté" so current in the civilization of our time.

THE INTERNATIONAL MENTAL HEALTH CONGRESS: A REPORT

By MARY E. SWITZER*

It is always a great pleasure to come back to Topeka, and especially to participate in the Annual Meeting of the Foundation. The International Congress on Mental Health in London was in a way a much expanded Annual Meeting. It had many of the same characteristics. Those of you who are not acquainted with the way the London Congress was organized would find it worthwhile, I think, to have a little of its background because it is significant in evaluating what went on in London and also necessary to understand the kinds of things that were done there and what are the advantages and limitations.

Psychiatry and the sciences related to it took a great step forward during the war, not only in our country but in almost all of our allied countries, especially in Great Britain. The forces that were responsible for developing modern dynamic psychiatry were eager, before the information and impetus got stale, to bring together professional groups from all over the world, to concentrate on a central theme, and to see what would evolve from an international conference on mental health. It was also the conception of the planners that this Congress should not be "just another meeting" or "just another series of scientific papers," but rather should be a group endeavor and represent the best example of group thinking that psychiatrists could stimulate as a result of the war situation.

It was felt that the first purpose of the Congress must be a mutual appeal not only to physician psychiatrists but to all the other professional workers whose service had been found to be so useful in improving mental health during the war. It was decided to have as many groups as possible all over the world meet for a year prior to the Congress to discuss various aspects of mental health, and to come to some consensus. It was hoped in these various commissions there would be included psychiatrists, psychologists, social workers, teachers, counselors, nurses, and even just plain citizens. So in the year preceding the Congress, many groups met together all over the world, developed statements of policy and sent them to London. Here in America there were two national commissions and over 100 small ones. One of these was the Commission on the Effect of War on Children, and the other was the Commission on World Citizenship. When this material was received in London, a skillful group analyzed it, edited it and put it in easily usable form for the Congress members. . . .

Three weeks before the Congress, representatives of about twenty

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nations met together for a fortnight, took the material which had been worked up by the commissions, mulled it over, talked about it, fought about it, and came out with a document that is known as the statement of the International Preparatory Commission. This document will be significant because it was actually evolved by this international group. It will become a text to be used in educating all of our people in the principles of mental health. It will become a point of departure and a charter for planning work not only internationally but nationally. It sets down certain principles, facts and needs in interesting fashion, with rather unusual foresight and I think with special insight into the present day needs. It can be used by groups interested in mental health and world citizenship everywhere to challenge the attention of legislators, governors, public officials of all kinds, teachers, and communities. This document is useful, not only because it represents an agreement reached by representatives of some twenty-odd countries, but because it contains a framework of recommendations which will be used by the World Health Organization, UNESCO, and other international groups who are working in the field of health and allied interests.

The Congress itself was in three parts: Child Psychiatry, Medical Psychotherapy, and Mental Health and World Citizenship. Plenary sessions gave speakers and discussants an opportunity to expand ideas in these areas. Twenty small discussion groups met daily to discuss various aspects of the International Preparatory Commission's statement and the summary at the final session brought the highlights of all of these into focus. At the Congress there was hardly a session or hardly a day that the importance of work with children was not emphasized. So it is not unusual this year that we should stress at the Annual Meeting of The Menninger Foundation the importance of the work of our Children's Division, and the importance of all work with children. If there was any one thing emphasized at the London Congress, and if there were any people more earnestly received than any other group, it was those who had wisdom and vision in this field. While recognizing the importance of work with children, the discussants did not fail to realize that many of us are no longer children, and so the many ways in which psychiatry can help adults, also, achieve better mental health were not overlooked. The discussions on this point were most helpful when they pointed to certain periods in the lives of all of us when we are most susceptible to help. Adolescents, of course, were mentioned as a key group, and we were reminded that community crises—waves of juvenile crime, especially high incidence of alcoholism, waves of industrial unrest—often give a golden opportunity to apply psychiatric knowledge.

There was unanimity of conviction that good mental health for everyone

is essential if we are to achieve peace, and this goal depends primarily on what is done for the child in the family. Therefore the whole question of world citizenship was approached in two ways: in relationship to the individual and in relationship to the family. Although the meeting was mostly of psychiatrists and the majority of the speakers were physician psychiatrists, it is significant that most of them emphasized the social and community aspects of child development. It became obvious that dynamic thinking now dominates our concept of the family and that what we have learned of personality development in the last thirty to forty years has come from the psychoanalysts. It was equally obvious that the concept of the individual as a product chiefly of interpersonal relationships is accepted, not just by those who have studied psychoanalysis, but by most of the psychiatric world.

Representatives from nearly every country spoke of the great need for child psychotherapists. Most vocal were the English and the Dutch. In England, a Commission headed by the Minister of Health and composed of psychiatrists, guidance people, teachers, etc., is now studying the whole problem and is planning to set up standards for the training of child psychotherapists. Someone referred to this as a "new profession." The training is to take place in well-established and approved agencies like the Tavistock Clinic. The Dutch delegate, as did others, deplored the fact that therapeutic work with children is not sufficiently supervised, that many poorly-trained people are in practice. Anna Freud, serene, calm-eyed, charming, was the star of this session.

Much was said about the adolescent and the increase of delinquency at this age. The needs for scientific study, for therapy and for more institutional care, especially in European countries, were stressed. The experiences of war, with its emphasis on destruction, were poor ingredients for character building. Another disadvantage of the European adolescent is that he is now too old to be eligible for the extra food ration of the younger children. He is treated like an adult before he is physically or emotionally ready. These young people, many without parents, are regarded as a political as well as a social menace for the future. Lawrence Frank said this may be the strategic group on which to concentrate our energies. Institutions for the adolescents, youth organizations and children's villages are helpful, but are still far too few.

There was a great deal of discussion on the desirability of increasing emphasis on the nursery school situation. The nursery school was felt to be not a substitute for home but a way to help the family bear the greater responsibilities of today and an adjunct to the family in helping the child toward good personality development. One could recognize in the Congress at this point, that the discussions lacked the material that

could have come from a larger involvement of classroom teachers. One of the recommendations made by many of the small discussion groups was to that very point: that classroom teachers are one of the most important groups through which good health everywhere can be effected. It seemed to me there was a great deal of groping among the highly professional psychoanalysts and psychotherapists as to how to make the advanced psychiatric skills available in the school situation. Everybody was acutely aware of the need, and regretted that the Congress did not provide enough material on how it could be done. There was a certain feeling of frustration on the part of many of us that this particular phase did not receive more attention. Not enough emphasis was placed on bringing teachers into the pre-Congress discussions.

Another very interesting part of the conference was the Medical Psychotherapy section. The papers were concerned with collective guilt, and its effect on the modern world. Many of them conveyed a realization of what ought to have been a more personal concern for the misuse of human responsiveness which led to the two world wars of our generation. There was evidence of a searching for some method to suggest to our leaders and our governments how the knowledge disclosed to us through psychiatry could be a constructive force for peace. This preoccupation with the world scene and its implications might create the impression that the Congress felt that psychiatry properly applied could solve all the complexities of our present world. There was no such lack of humility in the minds and hearts of those gathered in London. Most of those present knew only too well the difficulty of applying the simplest truths concerning human behavior to their own immediate situations, let alone trying to forge a plan of action for the political arena of nations. They tried to stress, however, both for themselves and the world, that workers in this field have a special responsibility because their profession gives them peculiar insight into the motivations of men, and knowledge which should help in the understanding of human behavior.

I had some interesting talks with psychiatrists and some of them did feel it was presumptuous of the conference to suggest they ought to help influence international relations at all—that anything which minimized the doctor-patient relationship was a disservice to psychiatry. I felt deeply that this point of view is narrow, if not wrong—since I know how much even a little knowledge of the principles of psychiatry had helped me and I did not acquire this knowledge, such as it is, in the doctor-patient relationship. I was at a loss for just the *bon mot* when I came across a quotation from Freud which reassured me. In 1935 Dr. Gustav Bychowski, author of *Dictators and Disciples* asked Sigmund Freud, "How can we devote our time and energy to curing a few individuals at a time like this

when our entire civilization, our very existence, is imperiled?" Freud answered that psychoanalysts could not save mankind but that they could help by popularizing their knowledge; if psychoanalysis became a part of universal thought, "the day might come when these horrifying reactions of the collective psyche would no longer be possible."

In the section of the Congress devoted to Mental Health and World Citizenship, there was emphasis on the need for an over-reaching loyalty beyond the narrow confines of our own country. This plea for understanding was made eloquently by two Americans, Carl Binger and Margaret Mead, who warned us against the dangers of western professional imperialism. We were acutely aware of how different were the motivations of our colleagues from the occupied countries and from behind the "Iron Curtain." The difference in motivations between them and ourselves is equalled only by the difference in language. The Preparatory Commission recognized that the job of public education is, perhaps, the most important of all and made several first-class suggestions for achieving a better community understanding in its report.

In addition to attending the London Congress, perhaps because of it, I had an opportunity to go into the American Zone of Germany. The problem of children, what to do with them, and how to deal with them is probably the most challenging and urgent problem in Germany. All kinds of delinquency problems, group problems, and ordinary school and family problems are magnified in Germany because life is so physically difficult. Their solution is made more difficult because of the German personality and the tradition, or lack of it, in relation to citizen organization for community purposes.

I visited several German schools in Wiesbaden and saw the children. I wondered whether the German teachers and educators have the spirit and the understanding to carry the children through these years of transition. In London, a great many of the psychiatrists, particularly those who had worked in Germany, or had experience with children in occupied countries during the war, made the very important point that children who are just now reaching adolescence were brought up in a war situation where a premium was placed on aggression. Now it is an almost superhuman task to deal with these children. Some typically American efforts to deal with the situation are evident, however. Among children in Germany our Army people are carrying on a program similar to our own police boy's-club group work. A young G. I. became interested in the German boys around him, encouraged them in sports, and now there is an extensive program of youth work being carried on by the military people themselves. In Frankfort, attached to the program of the Military Hospital, interestingly enough, the man who was directing the program and

working with the boys was a school teacher from Kansas. So even there you see the Kansas beam.

Another phase of the work in Germany which is encouraging is the development of good relationships in the health and medical fields. I suppose it is only natural that it is easier to drop antagonistic feelings when the basic concept of a profession is healing. I felt very strongly in visiting the German hospitals there had been a great deal of encouragement and assistance given to the German staff in those hospitals by our military government people who worked with them to develop a well-organized hospital service once more. Germany is about the only place I have heard of where there is not a shortage of nurses. It was inspiring to sense the devotion of the nurses and I am told throughout Germany the nurses have been one of the firmest parts of the health program there.

In going from a psychiatric congress to France and Germany, one is grateful, very grateful, for the knowledge represented by the work that is going on here in Topeka and elsewhere. Though we may be impatient with the generalities of a conference like London, we are profoundly thankful that London wanted us at this time when Britain as a whole has so many restrictions on living. It was a great satisfaction to have been a part of an effort to set out the ideal of world citizenship; to visualize a set of goals recognizing the importance of the child today, and, above all, to realize that we came a little way on the road to world citizenship and world peace.